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ABSTRACT

Presented at the 1980 annual meeting of the National Association of School Psychologists, the paper discusses two areas in which school psychologists can make significant contributions to facilitate the mainstreaming of mentally retarded children: staff training and supportive and counseling services to parents. Two intervention strategies that have proven successful in dealing with disruptive behavior are reviewed: overcorrection and timeouts. Other aspects covered include the writing of behavioral objectives, crisis intervention techniques, home management techniques, the child's transition from an institutional to a home setting, parent attitudes, and family counseling. (DLS)

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MAINSTREAMING THE MENTALLY RETARDED:

SERVICES TO SCHOOL PERSONNEL AND FAMILIES OF THE HANDICAPPED CHILD

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Public Law 94-142 has brought great numbers of previously institutionalized mentally retarded and developmentally disabled children into the mainstream of public school life. This mainstreaming experience is fraught with great possibilities and challenges not only for the students, but for their families, parents and teachers as well. The school psychologist is in a particularly advantageous position to assist teachers and parents in meeting these challenges. In this presentation, I would like to discuss two areas in which school psychologists can make significant contributions to facilitate the integration of handicapped children into the schools - 1) staff training; 2) supportive and counselling services to parents.

If the New York City experience is characteristic of the rest of the country, then it can be said that teachers are ill prepared to meet the needs of the special children they now face in their classrooms. With increasing frequency, children who are unable to feed, dress or toilet themselves are now entering the schools. Oftentimes, classroom management difficulties are compounded by the presence of children who exhibit self-abusive behavior or aggressive behavior towards others.

How then to even begin approaching this problem? Research as well as practical experience has shown us that the use of behavioral techniques is particularly effective with low functioning individuals. Many school personnel, including teachers and paraprofessionals, lack a basic understanding of the theory and application of behavior modification techniques. A thorough understanding of these techniques is vital not only for instructional purposes, but for developing Individual Educational Plans as well. Psychologists can begin to train staff by illustrating task analysis approaches to teaching training objectives. Simply stated, this means that objectives are broken down sequentially into their component steps. This is particularly useful to teachers

in that task analyses specify particular starting and ending points, and additionally, instruction can be individualized for each student. Since the skill level of the student determines the entry level for the task analysis, it is important for school personnel to develop good facility at observing and attending to small increments of behavior. A useful exercise in this regard is to have a staff member act out a particular motor activity, and to ask the training group to specify its component steps.

A major concern that teachers have is the writing of behavioral objectives. Oftentimes not trained in a writing style which requires technical and specific data, some teachers have great difficult translating teaching techniques into quantifiable numbers. These difficulties are not unique to public school teachers, and at Staten Island Developmental Center we have developed a manual for professional and nonprofessional staff. The manual serves both as an assessment tool as well as a curriculum guide. It contains task analyses and specific programmed interventions for over 50 motor and academic activities. The intervention section specifies the conditions, behavior, commands and success criteria for each of the activities. School based psychologists may want to consider developing a similar manual to incorporate curricula being utilized in their own schools. Presenting academic material in this manner is of great value to teachers in writing Individual Educational Plans.

The technology of teaching is simply not sufficient to insure effective classroom learning. The skill and flexibility of the individual are perhaps the most important competencies for the special education teacher. With the assistance of the teacher, the psychologist can identify the types of reinforcers or rewards a student is responsive to. No doubt as a result of the social isolation in which institutionalized children lived, these children are particularly responsive to praise and the attention of others. In selecting a reinforcer, it

is vital to consider its appropriateness to the social milieu in which the student lives. An example of this took place at our facility, where a resident was given cigarettes as a reinforcer in a training program. This resident became so addicted to cigarettes that she became dangerously violent when they were withheld from her. School personnel also need to be aware of a possible over-protective attitude towards the handicapped, whereby although students may have the ability to complete a task, things are simply done for them. It is preferable to set up mildly frustrating situations which provide an impetus for the child to learn. Thus, before giving a child an afternoon snack, have him name the food to be eaten, or, before giving the child the correct response in a sorting task, have her choose all possible options. Finally, the psychologist can perform a useful function in working with the teacher to explore new and creative ways of using instructional material, seizing a crucial moment to teach a task, or modifying a teaching approach to suit a particular child.

For staff members working in state institutions, it is not unusual to see residents throw objects at each other, attack peers or ward staff, or engage in self-abusive behavior. Children who manifest significant behavioral and emotional difficulties can now be found in the public schools, thereby presenting a major management problem for school personnel.

There are some general principles which can be utilized in dealing with behavior problems in the classroom. When we talk about strategies in dealing with aggressive behavior, we are really discussing two separate events. First, what happens at the moment the behavior occurs, and second, what occurs afterward. There are some simple, common sense rules which can be utilized in a crisis situation where a child or teacher is being attacked. Do not panic is the first rule. In a crisis situation, it is crucial for the staff member to maintain control over what can be a potentially explosive situation. At some point early

in the crisis, a determination should be made if assistance is needed, and if so, to summon help immediately. For this reason, it is important to leave some access to the door as a means of escape. Once a determination is made that the situation can be handled with the available personnel, begin to yell and scream. By yelling or talking loudly, for instance "Put down the chair," the voice serves as a verbal cue for some type of punishment or reprisal to follow afterwards. If this does not succeed, it is sometimes necessary to institute some physical restraint procedures. Either by oneself, or with the assistance of another individual, it is crucial to pin the person's arms and legs so he cannot strike out. For the psychologist working with such acting out students, it is a good idea to institute some formal type of training, and to make a dry run of these procedures before the need arises.

What I have discussed above are essentially crisis intervention techniques. In the long run, it is more important to determine what set off the behavior to begin with. When we speak of setting up long term intervention programs, we start with the assumption that all behavior, whether we can detect its motivation or not, is purposive and goal directed. The ABC's of behavior modification helps to conceptualize this approach. "A" for antecedents, "B" for the behavior itself, and "C" for the consequencies of the behavior. Antecedent variables which may play a part in setting off the behavior may be the time of day - Was it before meals? Was the regular teacher absent? Did the child act out after his desk was moved? All this information is vital in preventing recurrence of the behavior.

Looking at the behavior itself, are there any patterns that emerge? Is aggression always directed towards the same person? Who is present in the room when the behavior occurs? The last and perhaps most important part of establishing a behavior management program is to examine the reactions of people present at the behavior's occurrence. Oftentimes, staff reward inappropriate behavior. For

example, it is not unusual for a child to develop a behavior problem immediately after she is given an assignment by the teacher. The scenario may be something like this: Teacher gives assignment, child turns over desk, teacher says "Okay, just sit there and don't bother anybody." This child has learned that in order to get out of doing work, she needs to be disruptive.

There have been some interventions which have been proven successful in dealing with disruptive behavior in a variety of settings. I will briefly review two of these interventions - the use of overcorrection procedures, and the use of timeouts.

Overcorrection or positive practice is a procedure popularized by Nathan Azrin from Illinois. Put succinctly, overcorrection says that the behavior disrupter has to correct the consequences of his act to a vastly improved state, as to what it was before the disruptive behavior occurred. Thus, a child who has turned his desk over is asked to right his desk, as well as arrange all other desks in the room. Or, a child who threatens another child is asked to apologize to that child as well as to all other individuals in the room. The restitution should be directly related to the act itself, it should follow immediately after the behavior, and there should be no other reinforcing activities going on while restitution occurs.

The use of timeouts is another type of punishment technique. This consists of confinement to a timeout room or area, removal of a reinforcing agent, or removal of the reinforcer itself. Depending on the legal constraints of a particular setting, this procedure may result in a child's being placed in a timeout area in the classroom, or in a one-to-one work situation, turning the child's chair around when a disruption occurs. The important ingredients here are the consistency and regularity of reaction among staff working with the child.

In summary, the job of the psychologist in dealing with the aggressive mentally retarded child is to work with the teacher in altering the classroom environment to maximize the learning potential of each child. This may mean utilizing some of the punishment techniques discussed above, but more importantly, the psychologist and teacher should work together to strengthen socially adaptive behaviors to compete with aggressive behavior. Liberal use of verbal praise, modeling appropriate behavior, and slowly accustoming the child to difficult tasks are tools available to us.

Supportive and Counselling Services to Parents

The parent of a physically, mentally or emotionally handicapped child carries a very heavy burden. The life experiences of such parents are often quite debilitating, and these experiences inevitably impact on the child attending school. Research indicates that parents of developmentally disabled children exhibit a lowered sense of self-esteem, a deep sense of loss, depression and other symptoms of psychological stress. The financial burden of caring for a handicapped child is also great, and ironically, financial supports are greater for the once institutionalized child who has returned to his natural home, than for the child who was never institutionalized. The psychologist working with such families can be of help at two different levels: 1) Concrete services; 2) Supportive and counselling services.

As all of us who work in large state, county or municipal systems are aware, making sense of the system can sometimes be a lifelong task. The vast array of service providers, each with their own unique service, admissions criteria, and funding mechanisms can be unintelligible to even the most knowledgeable and sophisticated parent. It is at this informational level that the psychologist can make his first useful intervention. Through the formal vehicle of his position on the Committee on the Handicapped or through informal contacts with parents, the

psychologist can serve as an advocate for the parent. Parents often ask questions about the meaning of various terms, the availability of services or the appropriateness of a particular educational or vocational setting for their child. Competencies in the area of program evaluation whereby clinical impressions about the type and quality of services are made, are essential for the psychologist to perform this service.

Yet another service which can be provided to parents of developmentally disabled children is training in management techniques at home. Although children receive the benefits of a full day educational program, these skills do not always generalize to the home. Parents are often in the dark about training in independence skills. The techniques about managing disruptive behavior discussed above can also be taught to parents. Parents are oftentimes preoccupied with toilet training their children. Through relatively simple means, parents can be taught to schedule their children on a regular basis, thereby preventing toilet accidents. At a more advanced level, some children are capable of self-initiating, and here too the psychologist can be helpful in establishing a training program.

Parents or guardians of children who have recently left an institutional setting have additional concerns to deal with. The nature of institutional life is such that all activities are highly regimented and structured. Thus, an individual may have been following the same time schedule of sleeping, waking, dressing and eating for many years. Inevitably, these habits will carry over to the home, as may such habits of stealing or hoarding food. The psychologist can help prepare parents to expect these types of behaviors, and to account for this regimentation when planning the day for their child.

An additional distinguishing feature of institutional life which will impact on a child's adjustment to a new home and school is the great deal of dependency

which is nurtured in institutions. Because there is little emphasis placed on doing things for oneself, it should be expected that ex-institutional children may make little or no attempt to initiate activities or complete tasks independently. This phenomena has been referred to as "Learned Helplessness" in the literature. Parents should be made aware that what may appear as apathy, listlessness and depression is in fact a long-standing mode of dealing with the world. A solution to this is to engage the parent and child in active, collaborative attempts to develop self-help and independence skills. "Learned Helplessness" is not irreparable, and parents should be cautioned about overprotecting their child. More than any other type of therapeutic intervention, training parents requires the psychologist to go into the home, observe the physical layout, note interactions among family members, and identify areas in which he can be of help.

Perhaps the most intensive type of therapeutic intervention which can be effected is the provision of counselling services to families of developmentally disabled children. For many families, the experience of having a mentally retarded child threatens to destroy the very fabric of family life. Our experience with such families suggests that the decision to institutionalize a child is one of the most heart rending they can make. Some parents suffer from a sense of guilt which stays with them all their lives, while other parents simply cannot accept their child and shut the child out of their lives forever.

Before one can effectively work with such families, it is important for the clinician to recognize his or her own biases. A common one, particularly in light of the publicized horrors of institutional life, is to blame the parent for their actions. It is important to place the decision to institutionalize in its proper historical and sociological perspective. The deinstitutionalization movement did not come about until the 1960's. Prior to that time, it was considered

acceptable, even advisable not to keep the severely handicapped child at home. A review of a client's history will often turn up a letter from the family physician to the facility director recommending institutionalization "For the good of the family." This referral system worked so well that its high point in the early 1970's, Willowbrook had a population of over 6,000 residents. It was the rare parent indeed who was able to withstand the psychological and financial pressure not to institutionalize their child. Clinicians can be helpful to such families by simply not blaming them for their actions, and thereby not reinforcing the parent's sense of guilt.

Early on, the psychologist should make a determination of the feasibility to seeing the family in treatment or if referral to an outside agency is more advisable. In either case, there are a number of issues of importance to clinicians which inevitably emerge.

The parent who has carried the major burden of responsibility for the child, usually the mother, often carries with them a sense of helplessness and feeling of being trapped. These feelings of anger may be internalized in the form of depression, or they may be directed as blame against the spouse or other family members. Clinicians working with such parents should initially simply allow the person to ventilate some of these long held feelings of frustration and anger. Concomitantly, it is helpful to examine with the parent concrete, practical solutions to alleviate some of these burdens. For instance, exploring with the parent potential caretakers for the child to enable the family to take a vacation is a useful exercise. Other parents, particularly the elderly, are concerned about what will happen to their children when they die. Placement options can be explored with these parents, thereby engaging the individual in an active, constructive attempt to help their child.

Although mothers are oftentimes the seekers of assistance, there is clearly a need for help among all family members. The marriage itself may be under great

strain. Parents tend to blame themselves or each other for having a handicapped child. For this reason the clinician should endeavor to involve all family members in the course of treatment. Feelings of anger between spouses should be ventilated in a safe, protected atmosphere. So called "normal" siblings are the sometimes silent, sometimes acting out victims of the family problem. Siblings are oftentimes called upon to provide physical care for the handicapped youngster and are made to feel responsible for his or her welfare. Siblings oftentimes receive too little parental attention, given the tremendous needs of the handicapped child. Clinicians should look for signs of depression among siblings, or acting out in the form of getting into trouble or poor school grades among other siblings. Again, getting brother and sister into family treatment is beneficial to all.

The point of entry, and indeed the focus of treatment with such families, should be with the issues that the family presents as a problem. Some families may be doing very well on their own and may require only informational services. Other families may require some technical, hands on training in the home. Other families may express a willingness to work on some more long-standing, deep-seated issues that threaten family stability. With regards to families and marriages which appear to be at risk, the clinician should be aware of possible secondary benefits to be gained by keeping the handicapped child a "problem." Some parents devote themselves entirely to their child to the exclusion of all other social relationships. Still other couples focus on the problems of the child as a means of not dealing with difficulties in their own relationship. Again, the point of intervention for all these types of issues should be what the family presents as a problem.

In conclusion, the placement of handicapped children in the "least restrictive environment" brings both great promise as well as great challenges

to school psychologists. The manner in which we respond to these challenges will have a marked effect on the children themselves, their families and all others concerned with their welfare. It is now up to us to make good on the promise of mainstreaming, and in so doing, to help break down the walls of the institutions around us.